

IN THE
Supreme Court of the United States

OCTOBER TERM, 1989

FMC CORPORATION,

v.

Petitioner,

CYNTHIA ANN HOLLIDAY,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Third Circuit

**AMICI CURIAE BRIEF OF
THE TEAMSTERS HEALTH AND WELFARE FUND
OF PHILADELPHIA & VICINITY,
THE WESTERN PENNSYLVANIA TEAMSTERS AND
MOTOR CARRIERS WELFARE FUND,
THE DAIRY INDUSTRY-UNION HEALTH AND
WELFARE FUND OF PHILADELPHIA & VICINITY,
IBEW LOCAL UNION NO. 98 HEALTH AND
WELFARE FUND, AND CENTRAL PENNSYLVANIA
TEAMSTERS HEALTH AND WELFARE FUND
IN SUPPORT OF THE PETITIONER**

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| <i>Baxter v. Lynn</i> , 886 F.2d 182 (8th Cir. 1989) | 28, 29 |
| <i>Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1985) | 24 |
| <i>Council of Hawaii Hotels v. Aghalud</i> , 594 F. Supp. 449 (D. Haw. 1984) | 22 |
| <i>District 2, UMW v. Helen Mining Co.</i> , 762 F.2d 1155 (3d Cir. 1985), cert. denied, 474 U.S. 1006 (1985) | 2 |
| <i>Firestone Tire & Rubber Co. v. Bruch</i> , 109 S.Ct. 948 (1989) | 24 |
| <i>FHA v. The Darlington, Inc.</i> , 358 U.S. 84 (1958) .. | 22 |
| <i>FMC Corp. v. Holliday</i> , 885 F.2d 79 (3d Cir. 1989), cert. granted, 58 U.S.L.W. 3526 (U.S. Feb. 20, 1990) | 1, 12, 13, 14, 15, 16, 18 |
| <i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1987) | 23 |
| <i>Group Life & Health Insurance Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979) | 28, 29 |
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| <i>Insurance Board of Bethlehem Steel Corp. v. Muir</i> , 819 F.2d 408 (3d Cir. 1987) | 16 |
| <i>Memphis & Little Rock Railroad v. Dow</i> , 120 U.S. 287 (1887) | 27 |
| <i>Metropolitan Life Insurance Co. v. Massachusetts</i> , 471 U.S. 724 (1985) | 18 |
| <i>NLRB v. Amax Coal Co.</i> , 453 U.S. 322 (1981) | 1 |
| <i>NLRB v. Bell Aerospace Co.</i> , 416 U.S. 267 (1974) .. | 22 |
| <i>Northeast Department ILWGU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund</i> , 764 F.2d 147 (3d Cir. 1985) | 11 |
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| <i>Red Lion Broadcasting Co. v. FCC</i> , 395 U.S. 367 (1969) | 22 |

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| <i>Seatrain Shipbuilding Corp. v. Shell Oil Co.</i> , 444 U.S. 572 (1980) | 22 |
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| <i>Standard Oil of California v. Agsalud</i> , 633 F.2d 760 (9th Cir. 1979) <i>summarily aff'd</i> , 454 U.S. 801 (1981) | 20 |
| <i>Union Labor Life Insurance Co. v. Pireno</i> , 458 U.S. 119 (1982) | 29 |
| <i>United Mine Workers of America Health & Retirement Funds v. Robinson</i> , 455 U.S. 562 (1982) | 2 |
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| McCarran-Ferguson Act, 15 U.S.C. §§ 1101-015 <i>et seq.</i> | 26, 28 |
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| Periodic Payment Settlement Act of 1982, Pub. L. No. 97-473, § 301, codified at 29 U.S.C. § 1144 (b) (5) | 19 |

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| 128 Cong. Rec. 33,263 (1982) | 22 |
| 128 Cong. Rec. 33,240 (1982) | 22 |
| 128 Cong. Rec. 33,236 (1982) | 22 |
| 128 Cong. Rec. 33,183 (1982) | 22 |
| 128 Cong. Rec. 30,356 (1982) | 21 |
| 128 Cong. Rec. 30,352 (1982) | 21 |
| 128 Cong. Rec. 26,903 (1982) | 20 |
| 128 Cong. Rec. 26,902 (1982) | 20 |
| 120 Cong. Rec. 23,933 (1974) | 16 |
| <i>State</i> | |
| Statement of State Representative Andrew J. Cain, PR Newswire, January 10, 1990 (Available on NEXIS) | 15 |
| ADMINISTRATIVE MATERIALS | |
| 54 Fed. Reg. 4302 (1989) | 5 |
| SECONDARY AUTHORITIES | |
| Adler, <i>Employers Shift Focus to Controlling Costs of Mental Health Care</i> , Business Insurance, February 20, 1989 | 7 |

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| Adler, <i>Radical Changes in Benefits Loom</i> , Business Insurance, November 7, 1988 | 5 |
| A.M.A. <i>Urges Broad Health Plan</i> , New York Times March 8, 1990 | 9 |
| Appleman, <i>Insurance Law and Practice</i> (1981) (Volume 8A) | 11 |
| Benson, <i>Pharmacy Bill Would Target Private Pacts</i> , Pittsburgh Business Times & Journal, June 19, 1989 | 14 |
| Brostoff, <i>Mental Health Cost Soars, Report Says</i> , National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 26, 1990.. | 7 |
| Cave, <i>Direct Contracting With Hospitals: Alternative Payment Arrangements</i> , Employee Benefits Journal, June 1989 | 11 |
| Chase, <i>AIDS Patients are Living Longer Now, Two Large Studies of Disease Confirm</i> , Wall Street Journal, January 19, 1990 | 6 |
| Cohn, Fish & Enda, <i>How Interest Groups Mold Pa.'s Auto Insurance System</i> , Philadelphia Inquirer, October 23, 1989 | 15 |
| Congressional Research Service, Library of Congress, <i>Health Insurance and the Uninsured: Background Data and Analysis</i> (1988) | 3 |
| <i>Consensus Building, Not Legislation to Mark 1990, Johnson Tells Conference</i> , 17 B.P.R. (BNA) 222 (January 29, 1990) | 4 |
| Couch on Insurance 2d (Rev.ed.) (1983) (Volume 16) | 11 |
| DeWolf, <i>Health Care Benefits A Continuing Issue</i> , Philadelphia Daily News, January 12, 1990 | 4 |
| Division of National Cost Estimates, Health Care Fin. Admin., <i>National Health Expenditures, 1986-2000</i> , 8 Health Care Fin. Rev. 25 (1987).... | 5 |
| <i>Employers' Labor Costs Up 5 Percent Over 1988; Most Gains on Benefit Side</i> , 18 Daily Lab. Rep. (BNA) B-2 (January 26, 1990) | 4 |
| Enda, <i>Again, It's No Go for Pa. Car Law</i> , Philadelphia Inquirer, April 17, 1990 at 1, Col. 1 | 15 |

TABLE OF AUTHORITIES—Continued

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|--|------|
| <i>Estimates of HIV/AIDS and Projected AIDS Cases</i> , 39 Morbidity and Mortality Weekly Report (Centers for Disease Control) 110 (February 23, 1990) | 6 |
| Feldstein, Wickizer & Wheeler, <i>Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures</i> , 318 New Eng. J. Med. 1310 (1988) | 10 |
| Fish, <i>How Drivers Would Save Under the Insurance Plan</i> , Philadelphia Inquirer, February 6, 1990 | 13 |
| Fisher, <i>Health Benefits Found Surging As Strike Issue</i> , National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 5, 1990 | 8 |
| Fratcher, <i>Scott on Trusts</i> (4th ed. 1987) (Volume 2A) | 25 |
| Gannes, <i>Strong Medicine for Health Bills</i> , Fortune, April 13, 1987 | 11 |
| Gaul, <i>A Painful Lesson in the Economics of Medical Care</i> , Philadelphia Inquirer, April 9, 1990.... | 5 |
| Gaul, <i>Area Hospitals Undergo A Shakeout</i> , Philadelphia Inquirer, January 16, 1990 | 4, 5 |
| Gaul, <i>Employers' Costs of Health Benefits Rose 20.4% in '89</i> , Philadelphia Inquirer, January 30, 1990 | 4 |
| Gaul, <i>How 3 Companies Hold the Line on Health Costs</i> , Philadelphia Inquirer, April 9, 1990 | 11 |
| Geisel, <i>Health Benefit Tab Rises 19% to New High</i> , Business Insurance, December 11, 1989.... | 3 |
| Geisel, <i>Repeal of Section 89 Most Important Event for Benefit Managers</i> , Business Insurance, December 25, 1989 | 4 |
| Grossi, Yu, Astor & McCarthy, <i>The Pre-Estimate Program: An Effective Way to Reduce Surgical Fees While Preserving High Quality Care and Patient Choice</i> , Employee Benefits Journal, December 1989 | 4 |

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| Haggerty, <i>Direct Health Contracting Curbs Costs: Consultant, National Underwriter Property & Casualty/Employee Benefits Edition</i> , May 22, 1989 | 11 |
| Haistmaier, <i>Why America's Health Care System Is In Crisis</i> , Heritage Foundation Report, May 30, 1989 | 7 |
| Hall, <i>Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment</i> , 137 U. Pa. L. Rev. 431 (1988) | 15 |
| Handel, <i>The Renewed Surge in Health Care Inflation</i> , Employee Benefits Digest, December 1988.. | 5, 14 |
| Hastings, <i>Legal Developments in Managed Mental Health Care</i> , Physician Executive, November-December 1989 | 7 |
| HIV/AIDS Surveillance Report, U.S. Dept. of Health and Human Services, Centers for Disease Control, January 1990 | 6 |
| Hodes, <i>Drugs in the Workplace: New York State is Meeting the Challenge</i> , Employee Benefits Journal, March 1990 | 7 |
| Kalb, <i>Controlling Health Care Costs by Controlling Technology</i> , 99 Yale L.J. 1109 (1989) | 5 |
| Katz, <i>Fear and Trembling on Benefits Trail</i> , National Underwriter Property & Casualty/Employee Benefits Edition, December 5, 1988.... | 5 |
| Katz, <i>Meltdown Forces New Look At Benefit Plan Structure</i> , Life & Health/Financial Services Edition, January 4, 1988 | 2 |
| Kenkel, <i>Employer Costs of Group Health Benefits Take 17% Jump - Survey</i> , Modern Healthcare, February 5, 1990 | 4 |
| Kilburn, <i>Dole Winning Applause for Labor Department Actions</i> , New York Times, January 4, 1990 | 9 |
| Kittrell, <i>Large Employers Report More AIDS Cases: Survey</i> , Business Insurance, February 8, 1988 | 5 |
| Kolata, <i>Many Doctors Recommend Disputed AIDS Drug</i> , New York Times, March 19, 1990 | 6 |

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|---|-------|
| Kolata, <i>Radically Wider Testing of AIDS Drugs is Urged</i> , New York Times, March 26, 1990 | 6 |
| Lambert, <i>Bill to Seek \$500 Million in AIDS Disaster Funds</i> , New York Times, March 6, 1990 | 6 |
| Landes, <i>'89 Health Costs Rose 20%: Employers</i> , National Underwriter Property & Casualty/Risk & Benefits Management Edition February 19, 1990 | 4 |
| Lawless, <i>Cost Containment Through Outpatient Substance Abuse Services</i> , Employee Benefits Journal, March 1990 | 7, 10 |
| Leaf, <i>Cost Effectiveness As a Criterion For Medicare Coverage</i> , 321 New Eng. J. Med. 898 (1989) | 5 |
| Locke, <i>AMA Seeks Employer Mandate</i> , Business Insurance, March 12, 1990 | 9 |
| <i>Markets and Medical Costs</i> , Wall Street Journal, April 11, 1990 | 10 |
| Marwick, <i>Expanding AIDS Drug Availability</i> , 262 J. Am. Med. Ass'n 1289 (1989) | 6 |
| Milliman & Robertson, Inc., <i>Periscope</i> (January 1990) (Volume 2) | 5 |
| <i>More Workplaces Dealing With AIDS as Cases, New Treatments Increase</i> , 45 Daily Lab. Rep. (BNA) C-1 (March 7, 1990) | 6 |
| Nelson-Hurchler, <i>U.S. Catching Socialism?</i> , Industry Week, August 21, 1989 | 9 |
| <i>Ozzie and Harriet Package of Employee Benefit Funds</i> , The Chicago Tribune, January 1, 1989 | 11 |
| Pierce, <i>Health-cost Monster Needs to Be Tamed</i> , Philadelphia Inquirer, April 9, 1990 | 4 |
| Report of the Pennsylvania Bar Association Risk Force on Acquired Immune Deficiency Syndrome (November 11, 1989) | 6 |
| Restatement of Restitution, § 162 (1937) | 27 |
| Restatement (Second) of Trusts, § 176 (1959) | 24-25 |
| Restatement (Second) of Trusts, § 177 (1959) | 25 |
| Restatement (Second) of Trusts, § 181 (1959) | 25 |
| Rice & Mackenzie, <i>Cost of Injury in the United States: A Report to Congress</i> (1989) | 12 |

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|--|------|
| <i>Self-Insured Employees See Health Costs Rise 18%-Study</i> , Modern Healthcare, February 12, 1990.... | 4 |
| Sizemore, <i>Concerns on Cost Lead to Innovation-Pension & Benefits</i> , Fall 1989 | 11 |
| U.S. Bipartisan Comm'n on Comprehensive Health Care (Pepper Comm'n), <i>Recommendations to the Congress</i> , March 2, 1990 | 9 |
| <i>U.S. Urges Use of AZT For Adults With AIDS Virus</i> , New York Times, March 3, 1990 | 6 |
| Verespej, <i>Rx For Costs Elusive</i> , Industry Week, December 4, 1989 | 9 |
| Wagner, <i>AMA Proposes National Healthcare Reform Plan</i> , Modern Healthcare, March 12, 1990 ... | 9 |
| Webster's New Collegiate Dictionary, 250 (1973) .. | 24 |
| Wendling and Jost, <i>Resource Based Relative Value Scale: A New Challenge and Opportunity for Health Care Cost Management</i> , Employee Benefits Journal, March 1990 | 8 |
| Woolsey, <i>Most Health Plans Now Self-funded</i> , Business Insurance, January 29, 1990 | 3 |
| Wyatt Company, <i>Pepper Commission Suggests \$86 Billion Health Plan</i> , The Compensation and Benefits File, March 1990 | 9 |

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TEAMSTERS HEALTH AND WELFARE FUND
IN SUPPORT OF THE PETITIONER**

INTEREST OF THE AMICI CURIAE

This brief, which urges reversal of *FMC Corp. v. Holliday*, 885 F.2d 79 (3d Cir. 1989), *cert. granted*, 58 U.S.L.W. 3526 (U.S. Feb. 20, 1990), is submitted on behalf of five multi-employer welfare plans (collectively designated the "Funds") established pursuant to § 302 (c) (5) of the Labor Management Relations Act, 29 U.S.C. § 186(c) (5) ("LMRA"), and § 3(1) and (37) of the Employee Retirement Income Security Act, 29 U.S.C. §§ 1002 (1) and (37) ("ERISA"). Each Fund is based in Pennsylvania and, thus, presently covered by the Third Circuit's decision. The Funds exist for the exclusive purpose of providing health care benefits to participating employees and their dependents and are administered by Trustees, appointed in equal numbers by management and labor. These Trustees owe their exclusive fiduciary obligations to the participants and beneficiaries of their respective Funds. Therefore, the Trustees may not act in the interests of the employers or unions which appointed them. *NLRB v. Amax Coal Co.*, 453 U.S. 322, 332-34 (1981).

The Funds' interest in this case arises from the fact that they, like all health care providers, are presently confronted with a national crisis arising from explosive inflation in the cost of health care. Failure to combat this problem will prevent the Funds from providing adequate benefits to the men, women, and children who

rely upon them. The crisis is especially acute due to the manner in which the Funds are financed.

The Funds' income is set by collective bargaining agreements negotiated by constituent unions and employers. These agreements generally remain intact for several years. Even when labor contracts expire, there is no guarantee that labor and management can or will provide the Funds with adequate income.¹ Consequently, unlike insurance companies, the Funds have no power to respond to inflation by raising premiums. The only reliable alternatives for dealing with the current crisis are to cut costs or to reduce the available benefits.

To avoid reducing benefits, the Funds have implemented a series of cost containment measures, including subrogation provisions essentially identical to the policy of the FMC Salaried Health Care Plan ("FMC Plan"). Subrogation preserves finite trust assets by preventing duplicative compensation for one injury. Pennsylvania's limits on subrogation effectively require greater expenditures than necessary to provide treatment, a practice which is commonly called "double dipping." If the Third Circuit's decision remains intact, the Funds will have to expend large sums for such "double dipping." The result will be less benefits available for those eligible individuals who have no alternative source for financing medical treatment.

¹ See *United Mine Workers of America Health & Retirement Funds v. Robinson*, 455 U.S. 562, 570-76 (1982) (labor negotiators have an unfettered right to set contribution levels as long as they do not violate a specific federal law).

Many multiemployer plans are in industries which are either financially depressed or increasingly non-union. Since employers which contribute to such plans are often financially stressed, they have difficulty in making adequate benefit contributions. Katz, *Meltdown Forces New Look At Benefit Plan Structure*, Life & Health/Financial Services Edition, January 4, 1988 at 14. The current industrial strife caused by health care inflation further demonstrates the uncertainty inherent in relying upon the collective bargaining process. See *infra* notes 21-22, and accompanying text.

Perhaps more ominously, the logic of the Third Circuit's opinion would subject self-insured benefit plans,² including the Funds, to unlimited state interference with cost containment practices. As a legal matter, that result would flout the policies underlying ERISA. As a practical matter, such an outcome would severely injure self-insured plans and the persons who rely upon them.

I. THE FUNDS MUST IMPLEMENT EFFECTIVE COST-CONTAINMENT MEASURES IN ORDER TO PROVIDE ADEQUATE HEALTH CARE TO THEIR PARTICIPANTS AND BENEFICIARIES.

A. The Escalating Cost of Health Care Has Caused a National Crisis.

In 1987, the House of Representatives' Committee on Education and Labor and the Senate's Special Committee on Aging commissioned a study of health care in the United States. The final report noted that the cost of providing medical benefits "increased rapidly" from 1977 through 1983 and "slowed between 1984 and 1987." The report also cautioned that "increases for 1988 and 1989 are expected to resume the high growth rate of the early 1980's." Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis*, pp. 65-66 (1988). Unfortunately, that prediction was prophetic.

The United States Chamber of Commerce reported that the cost of providing health care insurance to employees rose by 19% in 1988.³ In 1989, costs increased an additional 20.4% nationwide, and an astounding 29.2% in

² As used herein, the terms "self-funded" and "self-insured" are synonymous, meaning a plan which pays benefits from its own corpus rather than by purchasing an insurance policy. Fifty-two percent of all employee health benefit plans, and 84 percent of those which encompass 20,000 or more workers, are self-insured. Woolsey, *Most Health Plans Now Self-funded*, Business Insurance, January 29, 1991 at 3.

³ Geisel, *Health Benefit Tab Rises 19% to New High*, Business Insurance, December 11, 1989 at 1.

the mid-Atlantic states, which encompass the Funds.⁴ The average employer's health benefit costs have risen from 5% of payroll to 18% over the last decade.⁵ Multi-employer plans, such as the Funds, have been saddled with even higher inflation rates.⁶ Furthermore, the AFL-CIO estimates that in the future "health care costs will continue to rise anywhere from 18 to 31 percent per year."⁷

⁴ These figures are based upon a survey of 1,943 employers conducted by A. Foster Higgins & Co. See Landes, '89 *Health Costs Rose 20%*; *Employers*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, February 19, 1990 at 27. See also Gaul, *Employers' Costs of Health Benefits Rose 20.4% in '89*, Philadelphia Inquirer, January 30, 1990 at C-1, col. 5; Kenkel, *Employer Costs of Group Health Benefits Take 17% Jump - Survey*, Modern Healthcare, February 5, 1990 at 3; Geisel, *Repeal of Section 89 Most Important Event for Benefit Managers*, Business Insurance, December 25, 1989 at 3, 13 ("In 1989, health care costs for indemnity plans increased 20% to 50%, while health maintenance organizations boosted premiums about 17% on average, several surveys found"); *Self-Insured Employers See Health Costs Rise 18% - Study*, Modern Healthcare, February 12, 1990 at 62; Gaul, *Area Hospitals Undergo A Shakeout*, Philadelphia Inquirer, January 16, 1990 at 1-A, 9-A, col. 3 ("Nationally health care expenditures rose from \$248 billion in 1980 to a projected \$647 billion in 1990—a 160 percent increase in a decade"); Peirce, *Health-cost Monster Needs to Be Tamed*, Philadelphia Inquirer, April 9, 1990 at 11-A, col. 5 ("[H]ealth-care costs [are] rising at three-times the rate of inflation").

⁵ *Consensus Building, Not Legislation to Mark 1990*, Johnson Tells Conference, 17 B.P.R. (BNA) 222, 223 (January 29, 1990). See also *Employers' Labor Costs Up 5 Percent Over 1988; Most Gains on Benefit Side*, 18 Daily Lab. Rep. (BNA) B-2 (January 26, 1990) (Bureau of Labor Statistics data shows that "health insurance costs rose at double digit rates throughout the 1980's, except for 1985 to 1987").

⁶ See Grossi, Yu, Astor & McCarthy, *The Pre-Estimate Program: An Effective Way to Reduce Surgical Fees While Preserving High Quantity Care and Patient Choice*, Employee Benefits Journal, December 1989 at 2 (noting that costs for multi-employer plans are rising "an average of 20-40%" on a national basis).

⁷ DeWolf, *Health Care Benefits A Continuing Issue*, Philadelphia Daily News, January 12, 1990 at 81, 82, col. 1. See also 2

1. The Causes of the Crisis.

There is no professional consensus concerning the genesis of the problem. Expert opinion, however, focuses upon factors beyond the control of plan fiduciaries. The single largest impetus to health care inflation arises from dramatic improvements in medical technology, which are expensive and usually prolong treatment. Technological advances account for approximately 50% of the current inflation in health care.⁸ These increases have prompted the Health Care Financing Administration to propose rules which include cost effectiveness as a criterion for Medicare funding of new technology.⁹

The AIDS pandemic has also fueled the crisis. According to a study by the Alexander & Alexander Consulting Group, in early 1988, "[t]he average per-case cost for treatment of AIDS was \$103,350."¹⁰ That study occurred as the present health care spiral was just begin-

Milliman & Robertson, Inc., Periscope (January 1990) (Over the next 18 months, health care costs will rise 12.5% nationally and over 22% in the Northeast United States); Division of National Cost Estimates, Health Care Fin. Admin., *National Health Expenditures, 1986-2000*, 8 Health Care Fin. Rev. 25 (1987) (By the year 2000, over \$1.5 trillion, or over 15% of GNP, will be spent on health care in the United States).

⁸ Kalb, *Controlling Health Care Costs by Controlling Technology*, 99 Yale L.J. 1109, 1112 (1989). See also Gaul, *A Painful Lesson in the Economics of Medical Care*, Philadelphia Inquirer, April 9, 1990 at 1-D, 7-D, col. 1; Handel, *The Renewed Surge in Health Care Inflation*, Employee Benefits Digest, December 1988 at 7-8; Katz, *Fear and Trembling on the Benefits Trail*, National Underwriter Property & Casualty/Employee Benefits Edition, December 5, 1983 at 9; Adler, *Radical Changes in Benefits Loom*, Business Insurance, November 7, 1988 at 14.

⁹ 54 Fed. Reg. 4302 (1989) (to be codified at 42 C.F.R. 400 and 405) (proposed on January 30, 1989). See Leaf, *Cost Effectiveness As a Criterion For Medicare Coverage*, 321 New Eng. J. Med. 898 (1989).

¹⁰ Kittrell, *Large Employers Report More AIDS Cases: Survey*, Business Insurance, February 8, 1988 at 3.

ning. The cost of caring for AIDS patients will continue to rise as the number of people with AIDS increases,¹¹ and new and expensive forms of treatment, such as the drugs azidothymidine ("AZT") and dideoxyinosine, become available.¹² This financial burden is particularly acute for the Funds, as Pennsylvania ranks seventh among the states in the number of reported AIDS cases¹³ and Philadelphia is one of the urban centers in the nation most seriously scourged by the disease.¹⁴

The national problem of substance abuse has provided a third stimulant to health care inflation. According to Nancy L. Hodes, the Executive Director of the Office of Employee Relations for the Governor of New York:

On any given day in the country, as many as 16 million employees are working under the influence

¹¹ *Estimates of HIV/AIDS and Projected AIDS Cases*, 39 Morbidity and Mortality Weekly Report (Centers for Disease Control) 110, 117 (February 23, 1990) ("AIDS cases in the United States will continue to increase through 1993").

¹² Marwick, *Expanding AIDS Drug Availability*, 262 J. Am. Med. Ass'n 1289 (1989); Kolata, *Many Doctors Recommend Disputed AIDS Drug*, New York Times, March 19, 1990, at B8, col. 1; Kolata, *Radically Wider Testing of AIDS Drugs is Urged*, New York Times, March 26, 1990 at A1, col. 3; U.S. *Urges Wider Use of AZT For Adults With AIDS Virus*, New York Times, March 3, 1990 at 10, col. 5; Chase, *AIDS Patients are Living Longer Now; Two Large Studies of Disease Confirm*, Wall Street Journal, January 19, 1990 at B2, col. 1; *More Workplaces Dealing With AIDS as Cases, New Treatments Increase*, 45 Daily Lab. Rep. (BNA) C-1 (March 7, 1990) ("Costs [of AIDS] are going up again because new treatments are extending the lives of patients and the drugs are expensive," according to Mark Rothstein, director of the Health Law Institute at the University of Houston).

¹³ HIV/AIDS Surveillance Report, U.S. Dept. of Health and Human Services, Centers for Disease Control, January 1990 at 6; Report of the Pennsylvania Bar Association Task Force on Acquired Immune Deficiency Syndrome at 15 (November 11, 1989).

¹⁴ HIV/AIDS Surveillance Report, *supra* note 13 at 7-8 (Philadelphia ranks sixth in number of reported AIDS cases among U.S. metropolitan areas); Lambert, *Bill to Seek \$500 Million in AIDS Disaster Funds*, New York Times, March 6, 1990 at A21, col. 2.

of illegal drugs—up to 25% of the workforce ages 20 to 40 . . . At the same time, they're driving health care costs to previously unimagined levels as they also reduce productivity and create workplace hazards for themselves and their co-workers.¹⁵

The costs resulting from this phenomenon are staggering. General Motors Corporation, for example, recently reported that "drug and alcohol abuse cost that firm \$1 billion a year."¹⁶ On a nationwide basis, treatment for substance abuse now accounts for 25%-30% of the total cost of employee health care, and many experts believe that the proportion could rise to 40% in the next few years.¹⁷

Finally, government responses to the problem have often had adverse side-effects. The vast majority of states have mandated benefit laws which require insurers to provide certain benefits. These laws have inflated the cost of services by increasing patient usage of the mandated services and by encouraging providers to raise their fees once a market for the mandated services is guaranteed.¹⁸

¹⁵ Hodes, *Drugs in the Workplace: New York State is Meeting the Challenge*, Employee Benefits Journal, March 1990 at 21.

¹⁶ *Id.*

¹⁷ Lawless, *Cost Containment Through Outpatient Substance Abuse Services*, Employee Benefits Journal, March 1990 at 6; Hastings, *Legal Developments in Managed Mental Health Care*, Physician Executive, November-December 1989 at 36 ("Between 1985 and 1987, psychiatric and substance abuse costs to employers increased 45 percent nationwide. The costs are now rising at about twice the general rate of medical inflation"); Adler, *Employers Shift Focus to Controlling Costs of Mental Health Care*, Business Insurance, February 20, 1989 at 17 "Some 20% to 25% of all employer health care expenditures go toward psychiatric and substance abuse treatment . . ."); Brostoff, *Mental Health Cost Soars, Report Says*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 26, 1990 at 45 ("Mental health costs grew by 27 percent between 1987 and 1988" with "more than 30 million American adults suffer[ing] from some form of mental illness").

¹⁸ Haistmaier, *Why America's Health Care System Is In Crisis*, Heritage Foundation Report, May 30, 1989 at 1.

Even attempts by the federal government to contain its costs have exacerbated the crisis for private employee benefit plans. For example, a recent amendment to the Social Security Act provides that all available private coverage must be exhausted before participants, or even spouses of participants, may qualify for Medicare payments.¹⁹ Title VI of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, moreover, has established a series of measures designed to reduce the costs of Medicare, including new physician fee schedules. These new schedules will tend to increase Medicare fees for family practitioners and internists, while reducing Medicare fees for a variety of specialists, including surgeons, radiologists, ophthalmologists, and dermatologists. Experts believe that this new system will provide a significant challenge to employee benefit plans, because family practitioners and internists will probably raise their fees for all patients, not simply Medicare patients, while the disadvantaged specialists will attempt to recover the lost revenue from non-governmental benefit plans.²⁰

2. Manifestations of the Crisis.

The seriousness of the crisis is illustrated by two remarkable developments. The first has been protracted labor strife. Approximately 60% of all strikes in the United States during 1989 were caused by disputes over health care benefits.²¹ The most prominent of these disputes, a nine-month strike in Appalachia involving Pittston Coal Company and the United Mine Workers, required the intervention of Labor Secretary Elizabeth Dole who, on the day of settlement, announced the appointment of a

¹⁹ Section 1862(b)(4) of the Social Security Act, 42 U.S.C. § 1395y(b)(4).

²⁰ Wendling and Jost, *Resource Based Relative Value Scale: A New Challenge and Opportunity for Health Care Cost Management*, Employee Benefits Journal, March 1990 at 2.

²¹ Fisher, *Health Benefits Found Surging As Strike Issue*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 5, 1990 at 31, col. 4.

special federal commission to study the issue of health care costs.²²

The second development involves the drastic proposals for resolving the problem presented by responsible commentators. Last year, Chrysler Corporation Chairman Lee Iacocca created headlines by joining other prominent industrialists in suggesting that the proper solution may be socialized medicine.²³ In March 1990, the United States Bipartisan Commission on Comprehensive Health Care, a panel appointed by President Reagan in 1988 and commonly called the "Pepper Commission," advocated a system of universal health coverage which would cost \$86 billion dollars. Of this figure, \$66.2 billion would be provided by the federal government and \$20 billion by private sources.²⁴ Even the normally conservative American Medical Association has proposed a system of national health insurance which closely resembles the recommendations of the Pepper Commission.²⁵ On the other extreme, the *Wall Street Journal* has tacitly endorsed taxing health care benefits, on the ground that forcing individuals to pay a greater percentage of medical

²² Kilborn, *Dole Winning Applause for Labor Department Actions*, New York Times, January 4, 1990 at 16, col. 1. See also Verespej, *Rx For Costs Elusive*, Industry Week, December 4, 1989 at 88.

²³ Nelson-Hurchler, *U.S. Catching Socialism?*, Industry Week, August 21, 1989 at 45.

²⁴ U.S. Bipartisan Comm'n on Comprehensive Health Care (Pepper Comm'n), *Recommendations to the Congress*, March 2, 1990 at 18-21; The Wyatt Company, *Pepper Commission Suggests \$86 Billion Health Plan*, The Compensation and Benefits File, March 1990 at 1.

²⁵ Wagner, *A.M.A. Proposes National Healthcare Reform Plan*, Modern Healthcare, March 12, 1990 at 2; *A.M.A. Urges Broad Health Plan*, New York Times, March 8, 1990 at B9; Locke, *AMA Seeks Employer Mandate*, Business Insurance, March 12, 1990 at 102.

bills will drive costs down by causing the public to conserve.²⁶

B. To Deal With the Health Care Crisis, the Funds Must Either Cut Costs or Reduce the Amount of Available Benefits.

Multiemployer plans cannot remain on the sidelines while the merits of the various proposals for reform are debated. Employees and their dependents need adequate health care on an on-going basis. As previously indicated, multiemployer benefit plans have no power to raise their contribution levels to meet the current waive of health care inflation. Therefore, the Trustees of such plans are between Scylla and Charybdis—they must either cut costs or reduce the amount of assets available for benefits. There is no other alternative.

C. An Effective System of Cost Containment Requires Elimination of Unnecessary and Duplicative Expenditures.

Experts unanimously agree that, to cut costs, benefit plans must limit needless and redundant expenditures by adopting programs such as: (1) a centralized record system to avoid repetitive diagnostic testing, (2) second opinion and utilization review programs, to prevent needless treatment, (3) increased resort to less costly treatment options, *e.g.*, outpatient care, (4) education of participants to help them avoid sickness, (5) establishment of networks of selected physicians who provide efficient treatment, and (6) direct negotiations with health providers such as hospitals, druggists, and physicians, in order to cut prices through volume discounts, preferred provider organization arrangements, and *per diem* contracts.²⁷

²⁶ *Markets and Medical Costs*, Wall Street Journal, April 11, 1990 at A 14, col. 1.

²⁷ *E.g.*, Lawless, *supra* note 17 at 6; Feldstein, Wickizer & Wheeler, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 New Eng. J. Med.

II. THE THIRD CIRCUIT'S DECISION CONSTITUTES A DIRECT THREAT TO EFFECTIVE COST CONTAINMENT AND, THUS, WOULD COMPROMISE THE WELL-BEING OF ALL PERSONS WHO RECEIVE THEIR HEALTH CARE FROM THE FUNDS OR SIMILARLY-SITUATED BENEFIT PLANS.

A. The Third Circuit's Ruling Would Drastically Limit the Right of the Funds to Contain Costs Through Subrogation.

The subrogation provisions at issue in this case are a form of cost containment. Their goal is to limit "double dipping."

This concept is hardly radical. The Funds' subrogation policy is highly analogous to "coordination of benefits," a practice which prevents duplicative compensation by prorating benefit payments between or among different insurers or benefit plans. The right to coordinate benefits is well-recognized in the context of insurance law. 8A Appleman, *Insurance Law and Practice* §§ 4906-010, at 341-492 (1981); 16 Couch on Insurance 2d (Rev. ed.) §§ 62.41-62.188, at 475-657 (1983). Coordination should be even more appropriate for self-insured ERISA plans, where the savings translate into benefits for other employees, as opposed to increased profits for insurance companies.²⁸ The only distinction between coordination of

1310 (1988); Sizemore, *Concerns on Cost Lead to Innovation*, Pension & Benefits, Fall 1989 at 13; Haggerty, *Direct Health Contracting Curbs Costs—Consultant*, National Underwriter Property & Casualty/Employee Benefits Edition, May 22, 1989 at 21; Cave, *Direct Contracting With Hospitals: Alternative Payment Arrangements*, Employee Benefits Journal, June 1989 at 26; Ozzie and Harriet Package of Employee Benefit Funds, Chicago Tribune, January 1, 1989 at 37; Gannes, *Strong Medicine for Health Bills*, Fortune, April 13, 1987 at 70; Gaul, *How 3 Companies Hold the Line on Health Costs*, Philadelphia Inquirer, April 9, 1990 at 1-D, col. 2.

²⁸ Ironically, the Third Circuit is the only court which has considered the extent to which coordination of benefits is applicable to ERISA. In *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985), the court indicated that coordination of benefits provisions are valid as long as they do not cause a participant

benefits and the Funds' subrogation policy is that the latter reduces expenditures in accordance with the amount paid by tort-feasors, rather than the amount provided by other benefit plans. The end result is the same, *i.e.*, more assets for other participants and beneficiaries.

If the Third Circuit's position remains intact, the Funds will be compelled to pay out hundreds of thousands, perhaps millions, of dollars to "double dipping" participants and beneficiaries whose claims stem from automobile accidents.²⁹ Such a torrent of needless and duplicative payments would directly reduce the amount of money available for benefits and would thereby contradict ERISA's avowed goal to safeguard such benefits.

B. New Legislation in Pennsylvania Threatens to Magnify the Adverse Impact of the Third Circuit's Decision Upon the Funds.

Under the Pennsylvania statute which existed at the time of the Third Circuit's decision, no fault automobile

to receive less than he or she would receive in the absence of alternate coverage. *Id.* at 161-62 n.13. The Funds' subrogation provisions, which only seek to prevent or recoup payments actually received from another source, would clearly pass muster under this test.

²⁹ The exact amount which subrogation saves benefit plans varies with time, depending upon the number of accidents, the size of the recoveries, and the solvency of the tort-feasors. *Holliday*, for example, is a case where the tort-feasor had limited insurance coverage and an obligation to pay multiple plaintiffs. Nevertheless, the plan could have saved approximately \$50,000 through subrogation. Thus, only a handful of accidents of this type can involve hundreds of thousands of dollars.

The amount at issue on a national basis is staggering. In 1985, the lifetime cost of medical and disability benefits arising from motor vehicle injuries in the United States amounted to \$48,683,000,000. Rice & MacKenzie, *Cost of Injury in the United States: A Report to Congress*, at 44 (1989). Figures are not available for subsequent years. Estimating an annual rate of increase at 10%, the figures would be \$53,551,300,000 in 1986; \$58,906,430,000 in 1987; \$64,797,073,000 in 1988; \$71,276,780,000 in 1989; and \$78,404,458,000 in 1990. These figures are conservative in light of the roaring rates of inflation currently experienced in health care.

insurance policies were required to provide a minimum medical benefit of \$10,000. 75 Pa. C.S.A. § 1711 (Purdon 1989). An employee benefit plan's obligation to compensate was not triggered until that sum was expended. 75 Pa. C.S.A. § 1719 (Purdon 1989); *see also FMC Corp. v. Holliday*, 885 F.2d at 81-83.

In February 1990, the Pennsylvania legislature enacted a series of amendments to the Motor Vehicle Financial Responsibility Law. The anti-subrogation provision remained fully effective.³⁰ The minimum automobile insurance medical benefit, conversely, was reduced to \$5,000.³¹ Furthermore, while the prior version of the statute contained an allowance for lost income—which the Funds provide in the form of disability benefits—that component was eliminated in the current statute.³²

If these amendments are sustained, their net effect under the opinion below would be a substantial increase in the financial obligations of self-insured ERISA plans which operate in Pennsylvania.³³ The reason for this increased liability is simple. The amendments would require ERISA funds to pay, without the benefit of subrogation, all but the first \$5,000 (rather than \$10,000) of medical benefits and all lost income arising from automobile accidents. These increased expenditures, in turn, would reduce the assets available for employees who do not "double dip."

³⁰ Compare 75 Pa. C.S.A. § 1720 (Purdon 1989) with Pa. H.R. Bill No. 121, 1990 Sess., Section 9 at 31 (signed into law February 7, 1990) (amendment to 75 Pa. C.S.A. § 1720).

³¹ See Pa. H.R. Bill No. 121, 1990 Sess., Section 9, at 27-28 (signed into law February 7, 1990) (amendment to 75 Pa. C.S.A. § 1711).

³² *Id.*

³³ Fish, *How Drivers Would Save Under the Insurance Plan*, Philadelphia Inquirer, February 6, 1990 at 4-A, col. 1.

C. The Third Circuit's Decision Threatens to Subject the Funds, and Other Self-Insured Benefit Plans, to Unfettered State Interference With Cost Containment Policies.

The challenge to sound cost containment policy is not limited to the specific mechanism of subrogation. According to the Third Circuit, state insurance laws are only preempted to the extent that they involve "core" ERISA concerns. *FMC Corp. v. Holliday*, 885 F.2d at 88. While the Third Circuit's definition of "core" is murky, the very holding of *Holliday* excludes cost containment measures, such as subrogation, from "core" concerns. This relaxed definition of ERISA preemption is very significant, because many cost containment measures are presently under siege in state courts and legislatures.

This siege is motivated by economics. Cost containment causes "a loss of revenue to health care providers."³⁴ Health care providers, in turn, have counterattacked, often resorting to state law.

Pennsylvania, for example, is experiencing an assault upon the ability of benefit plans to negotiate exclusive dealing arrangements with certain pharmacists in exchange for volume discounts. As previously explained, arrangements of this nature are strongly recommended by experts in the health field as an effective means for maximizing an ERISA plan's purchasing power.³⁵ A lobbying group for druggists named the Pennsylvania Pharmaceutical Association has proposed legislation to prevent insurance companies and ERISA plans from negotiating such contracts. This legislation has broad support.³⁶ If the legislation passes and is challenged on the basis of ERISA preemption, the pharmacists would certainly cite *Holliday* for the proposition that cost containment measures are not "core" ERISA concerns. Suc-

³⁴ Handel, *supra* note 8, at 7.

³⁵ See *supra* note 27, and accompanying text.

³⁶ Benson, *Pharmacy Bill Would Target Private Pacts*, Pittsburgh Business Times & Journal, June 19, 1989 at 15.

cess on such an argument would rob the Funds of another important method to contain costs.

Similarly, in *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989), a group of physicians argued that Michigan law prohibited a variety of widely-recognized procedures crafted to prevent unneeded or duplicative medical procedures, *e.g.*, preauthorization and concurrent utilization reviews. The court ruled against the physicians on the ground that ERISA preempted the state law in question. The Third Circuit's analysis, however, could lead to a contrary result. In that event, the physicians' lobby would pose an additional threat to the Funds and other self-funded benefit plans.³⁷

Yet lawyers probably pose the most potent threat to cost containment. The hostility of the plaintiff's bar to certain forms of cost containment is demonstrated by the various *amicus curiae* briefs which the Pennsylvania Trial Lawyer's Association has filed in support of the *Hollidays*, both in the Third Circuit, 885 F.2d at 85, and in this Court. Trial lawyers, moreover, are a powerful political force on the state level. In Pennsylvania, for example, they have played a major role in shaping automobile insurance laws, the source of the "double dipping" provision which gave rise to this litigation.³⁸

³⁷ As this brief was in its final stages of preparation, the Pennsylvania Medical Society and several allied groups obtained an injunction in the Pennsylvania Commonwealth Court which precluded enforcement of certain aspects of the state no-fault law which placed limits on medical costs. Enda, *Again, It's No Go for Pa. Car Law*, Philadelphia Inquirer, April 17, 1990 at 1, col. 1. This litigation further demonstrates the medical profession's political power and opposition to cost containment. See Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431, 536 (1988) (noting that, as a group, physicians are hostile to cost containment programs and "will use every weapon in their considerable arsenal to defend" against such policies).

³⁸ Cohn, Fish & Enda, *How Interest Groups Mold Pa.'s Auto Insurance System*, Philadelphia Inquirer, October 23, 1989 at 1-A, col. 1. ("[T]oday, as in 1983 [when the current automobile legis-

Congress fashioned ERISA to prevent encroachment from professional interest groups. During the legislative debate on ERISA, Senator Williams discussed preemption while delivering the report of the Conference Committee to the full Senate. As a floor manager of ERISA, his comments merit great weight. Senator Williams asserted that "[s]tate professional organizations acting under the guise of state-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." 120 Cong. Rec. 23,933 (1974). Significantly, the Third Circuit's opinion recognized the foregoing statement as an accurate expression of the Congressional intent underlying ERISA. 885 F.2d at 87. This recognition is ironic since the logic of the opinion below would place self-funded ERISA plans at the mercy of state laws enacted or invoked by "state professional organizations."³⁹

lation was enacted] a large part of the decision-making process has fallen under the influence of . . . the trial lawyers who profit tremendously from the state's insurance system"); Statement of State Representative Andrew J. Carn, PR Newswire, January 10, 1990 (available on NEXIS) (identifying the Pennsylvania Trial Lawyers Association as one of the organizations which "wrote the present laws governing auto insurance in . . . Pennsylvania").

³⁹ The traditional professions are not the only source of opposition to independent cost containment. State bureaucrats have a tendency to expand their power at the expense of self-funded plans. Such an effort has already been made in Pennsylvania.

In *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987), the Pennsylvania State Insurance Commissioner argued that the administrator of a self-funded ERISA plan fell within the jurisdiction of his department and, thus, was subject to all state laws concerning benefits. Had the Commissioner succeeded, the independence of such plans in benefit or cost containment matters would have been shattered. The Third Circuit rejected the Commissioner's argument, reasoning that an independent administrator is not engaged in the business of insurance and, thus, is not affected by the "savings clause" which preserves state insurance laws from ERISA preemption. 819 F.2d at 413.

Holliday indicates that the Third Circuit will not apply *Muir* when a party invokes a state insurance law directly against a plan,

In summary, the Third Circuit's decision threatens the integrity of the Funds' cost containment efforts and their independence from special interest groups. Consequently, the Funds have submitted this brief as *amici curiae*. The parties have consented to the Funds' appearance in this capacity, and copies of letters memorializing that consent have been filed with the Court.

SUMMARY OF ARGUMENT

The decision below should be reversed for three independent reasons. First, the Third Circuit's conclusion that the "deemer clause" of ERISA only protects "core" ERISA concerns is patently erroneous. The indicia of legislative intent, especially the evolution of the overall statutory scheme, demonstrate that Congress intended to insulate self-insured employee benefit plans from state legislation such as that involved in this case.

Second, the decision below would lack merit even if the Third Circuit were correct in concluding that the shield of the deemer clause is limited to "core" ERISA matters. Subrogation is designed to help effectuate the obligation of ERISA fiduciaries to preserve trust assets for the benefit of those who rely upon the benefit plan in question. By impairing these cost containment efforts, Pennsylvania has violated the "core" concerns of ERISA.

Third, the Pennsylvania statute is preempted irrespective of this Court's interpretation of the deemer clause. Subrogation is an equitable remedy which retains its vitality in the context of ERISA, by providing a means to conserve trust assets. Since the remedy is not limited to the insurance industry, state laws which relate to it are not rescued from preemption by the savings clause.

as opposed to an independent administrator. Hence, if the Third Circuit's decision in *Holliday* is not reversed, it may provide a basis for state domination of self-insured funds.

ARGUMENT

I. THE "DEEMER CLAUSE" OF ERISA, WHICH MUST BE READ IN CONJUNCTION WITH THE PERIODIC PAYMENT SETTLEMENT ACT OF 1982, CLEARLY INSULATES SELF-INSURED EMPLOYEE BENEFIT PLANS FROM STATE INSURANCE LAWS.

The Third Circuit's analysis in this case was three-pronged. First, the court found that the state statutory ban on subrogation was preempted by ERISA § 514(a), 29 U.S.C. § 1144(a). Second, the Third Circuit concluded that the "savings clause" of ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), exempted the case from ERISA preemption, because the Pennsylvania statute regulated insurance. Third, the court found that the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), did not reestablish preemption.

The Third Circuit's construction of the deemer clause confronted a significant obstacle. This Court's unanimous opinion in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) specifically recognizes "a distinction between insured and uninsured [*i.e.*, self-insured] plans, leaving the former open to indirect regulation while the latter are not." Instead of following *Metropolitan Life Insurance*, the Third Circuit rather condescendingly dismissed this Court's interpretation of the deemer clause as "dicta" supported by "neither statutory text nor legislative history." 885 F.2d at 89. In so doing, the Third Circuit committed a fundamental error.

As a preliminary matter, the discussion of ERISA preemption in *Metropolitan Life Insurance* is not an off-hand comment which a court of appeals may cavalierly dismiss. The *Metropolitan Life Insurance* opinion turns on a detailed analysis of ERISA preemption, including the legislative history re-sifted by the Third Circuit. Compare *Metropolitan Life Insurance*, 471 U.S. at 745-747 with *Holliday*, 885 F.2d at 86-89. In effect, the

Third Circuit has repudiated this Court's careful interpretation of the deemer clause.

Furthermore, for all its apparent concern with legislative history and the underlying intent of Congress, the Third Circuit ignored the effect of an integral amendment to the deemer clause enacted by the Periodic Payment Settlement Act of 1982, Pub. L. No. 97-473 ("PPSA"), codified at § 514(b)(5) of ERISA, 29 U.S.C. § 1144(b)(5). The PPSA provides that the preemption provisions of ERISA "shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51)." ⁴⁰ The establishment of this explicit exception for Hawaii illustrates the full breadth of preemption which applies to other states, such as Pennsylvania.

The PPSA must be read in light of two significant Ninth Circuit cases which preceded it. In *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978), the Ninth Circuit held that a California statute was preempted to the extent that it affected a self-insured employee benefit plan. The court explained that "[a]lthough Section 514(b)(2)(A) exempts from preemption state regulation of insurance, Section 514(b)(2)(B) provides that *employee benefit plans may not be considered to be in the business of insurance for purposes of the exception to preemption*." 571 F.2d at 504 (emphasis added). In short, *Hewlett-*

⁴⁰ The text of the exemption for Hawaii law established by the PPSA states, in relevant part:

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

Packard anticipated this Court's opinion in *Metropolitan Life Insurance* by concluding that the deemer clause exempts self-funded plans from state insurance law. This position, of course, flatly contradicts the Third Circuit's holding below.

One year after *Hewlett-Packard*, the Ninth Circuit considered the affect of ERISA preemption upon the Hawaii Prepaid Health Care Act, which required employers doing business in Hawaii to furnish employees with certain mandated benefits. Standard Oil of California, which maintained a self-funded plan for its employees in that state, brought a declaratory judgment action, arguing that the Hawaiian legislation was preempted by ERISA. Citing *Hewlett-Packard*, the Ninth Circuit agreed that the state statute was preempted. *Standard Oil of California v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1979), *summarily aff'd*, 454 U.S. 801 (1981). Hawaii then sought relief in Congress.

On October 1, 1982, Senator Robert Dole of Kansas reported the PPSA to the Senate on behalf of the Finance Committee. He noted that the bill "includes four provisions, each of merit and I believe noncontroversial." Senator Dole then introduced Senator Spark Matsunaga of Hawaii who discussed one of these provisions, *i.e.*, "a committee amendment which rescues the Hawaii Health Care Act from preemption by the Employment Retirement Income Security Act of 1974." 128 Cong. Rec. 26,902 (1982). Senator Matsunaga discussed the *Agsalud* litigation, describing the ultimate judicial determination that "the broad language of ERISA preempted all state law relating to private employee benefit plans including Hawaii's Prepaid Health Insurance Act." 128 Cong. Rec. 26,903 (1982). He noted that, in 1979, Congress had failed to pass a bill designed "to exempt from preemption state health insurance law" throughout the nation, and that opponents of the *Agsalud* decision had then limited their efforts to exempting "only the Hawaii statute." Without further debate, the Senate passed the bill unanimously.

On December 13, 1982, Congressman Dan Rostenkowski of Illinois introduced the PPSA to the House of Representatives. He noted that the House Committee on Education and Labor had amended the Senate's Hawaiian exemption by including language "to the effect that the exception made by this legislation is not to be considered a precedent for extending the exception to other state laws." 128 Cong. Rec. 30,352 (1982). Congressman John Erlenborn of Illinois then made the only significant speech on the Hawaiian proviso, in which he stated:

Last year the Supreme Court let stand the decision of the Ninth Circuit Court of Appeals in *Standard Oil of California* against *Agsalud* that the broad preemptive framework relating to pension and welfare (for example, health) plans agreed to by the ERISA conferees does in fact supersede the Hawaii statute. *The agreement to amend ERISA to permit the future application of the Hawaii law was reached solely on the basis and with the understanding that the Hawaii law is an unusual special case, inasmuch as the law was enacted just prior to the signing of ERISA on September 2, 1974, and that the law will be permitted to operate only as a narrow exception which is not expected to do violence to the strong Federal preemption scheme. In agreeing to the Hawaii exception this body will be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute.* To help allay the fears of those who might otherwise view this action as the beginning of a weakening of Federal preemption under ERISA, *the amendment contains an explicit statement that this limited exception shall not be considered a precedent with respect to extending similar treatment to any other State law.*

128 Cong. Rec. 30,356 (1982) (emphasis added).

The bill was then referred to the Conference Committee to reconcile the difference caused by the House amendment, which emphasized that this special provision would not serve as a precedent for any further state law

exemptions. The Committee recommended the House version, which was then enacted into law.⁴¹ 128 Cong. Rec. 33,183, 33,236; 33,240; 33,263; 33,433 (1982).

Read together, the deemer clause and the PPSA were intended to insulate self-insured ERISA plans which do not operate in Hawaii from regulation under state insurance laws. Thus, Pennsylvania's statutory ban on subrogation cannot apply to such plans.

The appropriateness of interpreting the deemer clause in light of the PPSA cannot be disputed. This Court has repeatedly recognized that "[s]ubsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction." *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 (1969). *Accord*, *Seatrains Shipbuilding Corp. v. Shell Oil Co.*, 444 U.S. 572, 595-596 (1980); *FHA v. The Darlington, Inc.*, 358 U.S. 84, 90 (1958). That principle is especially persuasive when a legislative amendment ratifies all or part of a prior judicial or administrative interpretation of the original statute. *NLRB v. Bell Aerospace Co.*, 416 U.S. 267 (1974); *Red Lion Broadcasting*, *supra*, 395 U.S. at 381-82.

This Court, moreover, has explicitly recognized that *Agsalud* is very relevant to interpreting the scope of ERISA preemption especially because the Ninth Circuit's decision was summarily affirmed. According to

⁴¹ The full text of the House amendment to the Hawaiian exception stated, "The amendment made by this section shall not be considered a precedent with respect to extending such amendment to any other State law." The amendment was eventually codified at § 301 of Pub. L. No. 97-473 and the notes to 29 U.S.C. § 1144.

The exception has been interpreted narrowly. Since Congress only excepted the "substantive provisions [of the Hawaii statute] in effect on September 2, 1974." 29 U.S.C. § 1144(b)(5)(B)(ii), the exemption does not cover collectively bargained plans, which the Hawaiian legislation did not attempt to regulate until 1978. *Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449, 455-56 (D. Haw. 1984). Thus, Taft-Hartley plans—such as the Funds—cannot be regulated by state law, even in Hawaii.

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987), state laws which affect the benefit structure of self-insured ERISA plans are preempted for the following reasons:

Agsalud . . . illustrates that whether a State requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same. Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all.

482 U.S. at 12-14.

There is no dispute that the FMC Plan, like each of the Funds, is a *bona fide* ERISA plan. If the Third Circuit's decision were to stand, ERISA plans would become subject to a wide variety of intrusive and conflicting state laws.⁴² These state laws would mandate the payment of benefits (including *duplicative* payments) in numerous situations. As demonstrated by *Fort Halifax* and earlier portions of this brief, the end result would be an incentive, and in some cases a necessity, "to reduce benefits or simply not to pay them at all." To avoid that untoward result, the decision below must be reversed.

II. THE DECISION BELOW SHOULD BE REVERSED EVEN IF THIS COURT WERE TO FIND THAT THE DEEMER CLAUSE ONLY PROTECTS "CORE" ERISA CONCERNS.

The Third Circuit's decision springs from the conclusion that the deemer clause only shields "core" ERISA concerns. Perhaps the most vivid defect in this fallacy is the fact that the Third Circuit had to invent the term "core," which is not used in ERISA, has no textual basis

⁴² Although the Funds are based in Pennsylvania, their jurisdiction extends to other states. For example, the Teamsters Health and Welfare Fund of Philadelphia & Vicinity has thousands of participants in Delaware and New Jersey. The petitioner's brief, moreover, demonstrates that the FMC Plan is national in scope.

in the relevant legislative history, and does not even have an apparent definition in this context. Yet whatever "core" may mean, the Third Circuit certainly intended it to involve matters of critical importance. Any other definition would do violence to the English language.⁴³ Judged by this standard, Pennsylvania's constraints upon subrogation clearly impair "core" ERISA concerns, arising from fiduciary obligations at the heart of the statute.

A. ERISA's "Core" Concerns Include the Fiduciary Obligations of Trustees to Preserve and to Maximize the Productivity of Plan Assets.

In enacting ERISA, Congress declared that the "financial soundness" and "equitable character" of employee benefit plans are critically important to the national interest. 29 U.S.C. 1001(a). Consistent with this finding, ERISA codifies many principles of trust law designed to protect plans, including the requirements that: (1) all assets (except those which consist of insurance contracts or policies) of employee benefit plans be held in trust, 29 U.S.C. § 1103(a), and (2) the individuals who manage such plans be fiduciaries bound by duties of exclusive loyalty and prudence. Furthermore, "rather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility." *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985) (emphasis in original, footnote omitted). *Accord, Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 954-55 (1989).

At common law, trustees have several well recognized duties which are particularly relevant to ERISA. First, a trustee must "use reasonable care and skill to preserve the trust property." Restatement (Second) of Trusts

⁴³ The definitions of the adjective "core" are: "a: a basic, essential, or enduring part (as of an individual, a class, or an entity) b: the essential meaning: GIST . . . c: the inmost or most intimate part." *Webster's New Collegiate Dictionary*, 250 (1973).

§ 176 (1959). Second, a trustee must "take reasonable steps to realize on claims which he holds in trust." Restatement (Second) of Trusts § 177 (1959). Third, a trustee has an obligation "to use reasonable care and skill to make the trust property productive." Restatement (Second) of Trusts § 181 (1959). *Accord*, 2A Fratcher, Scott on Trusts, §§ 176, 177 & 181 (4th ed. 1987).

The appropriateness of these rules in the context of ERISA is virtually self-evident, as they all support the "financial soundness" and "equitable character" of benefit plans. Their importance increases geometrically when viewed in context of the current national health care crisis. As explained above, expert opinion unanimously agrees that efforts to make the best use of plan assets must be redoubled in order to deal with spiraling inflation.

B. The Pennsylvania Statute Interferes With Trustees' Ability to Adhere to Their "Core" Fiduciary Obligations.

By adopting and enforcing subrogation policies, trustees of employee benefit plans comply with their fiduciary obligations. Every dollar saved through prevention of "double dipping" translates into an additional dollar available for actual treatment. The large volume of litigation engendered by the subrogation issue and the number of *amici curiae* which support reversal of the Third Circuit demonstrate that fiduciaries across the nation believe that subrogation is an important cost containment measure.

Conversely, the Pennsylvania anti-subrogation statute legislates a waste of plan assets, and thereby flouts the whole purpose of ERISA. It is difficult to conceive of a more fundamental clash between federal and state legislation. In every sense of the word, the Pennsylvania legislature has tread upon the very "core" of ERISA. Hence, the decision below cannot stand even if this Court adopts the Third Circuit's analytical framework.

III. THE "SAVINGS" CLAUSE OF ERISA DOES NOT PRESERVE THE PENNSYLVANIA ANTI-SUBROGATION STATUTE FROM PREEMPTION.

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) sets forth the test for applying the savings clause. The precise issue in *Pilot Life* was whether ERISA preempted Mississippi tort laws which created causes of action for bad faith denial of benefits. The defendant-plan was financed by a policy purchased from an insurance company. The plaintiff argued that the state law remedies regulated insurance, and, thus, were preserved by the savings clause. This Court disagreed and found preemption.

Pilot Life utilized a two-part test. First, the Court considered whether a "common-sense view" of the savings clause indicated that the state law in question should be preempted. The second was whether the state law applied to the "business of insurance," as that term is used in the McCarran-Ferguson Act, 15 U.S.C. §§ 1101-015. 481 U.S. at 48-49. The Pennsylvania anti-subrogation statute cannot survive either test.

A. Preemption is Appropriate Under the "Common-Sense" View of the Savings Clause.

The "common-sense" analysis turns on whether the historical roots of the state law in question arise from matters peculiar to the insurance industry. If not, then the savings clause does not apply.

The Mississippi torts at issue in *Pilot Life* dated to the early part of the twentieth century, when a series of state supreme court cases created a tort remedy for intentional breach of contract. Although the torts were most often asserted in connection with improper denial of benefits under an insurance contract, they were applicable to the intentional breach of other types of contracts. This fact was dispositive. According to *Pilot Life*:

A common-sense view of the word "regulates" would lead to the conclusion that in order to regulate in-

surance, a law must not just have an impact on the insurance industry, *but must be specifically directed toward that industry*. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, *the roots of this law are firmly planted in the general principles of Mississippi tort and contract law*. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

481 U.S. at 50 (emphasis added).

The savings clause is even less applicable to this case than it was to *Pilot Life*. Subrogation is much older than the insurance industry, dating back to Roman times. 73 Am. Jur. 2d Subrogation § 5 at 601-02 (1964).⁴⁴ Although the right to subrogate is commonly asserted by insurers, it is not so limited because, as a creature of equity,⁴⁵ the right can be invoked whenever necessary to prevent injustice. Restatement of Restitution § 162 (1937).

This Court, moreover, has recognized subrogation in non-insurance matters. *Prairie State Bank v. United States*, 164 U.S. 227, 231 (1896) (subrogation could be asserted by the surety of a government contractor); *Memphis & Little Rock Railroad v. Dow*, 120 U.S. 287, 302 (1887) (trustees of mortgaged property entitled to subrogation in order to recover legal expenses incurred in defending mortgaged property against lien asserted by the state).

⁴⁴ As Chief Justice Vanderbilt explained on behalf of the court in *Standard Accident Insurance Co. v. Pellicchia*, 15 N.J. 162, 171, 104 A.2d 288, 292 (1954), subrogation "is a right of ancient origin, having been imported from the civil law to serve the interests of essential justice between the parties."

⁴⁵ *Aetna Life Insurance Co. v. Middleport*, 124 U.S. 534, 549 (1888).

In contrast to the Third Circuit, the Eighth Circuit has held that state laws which impair the subrogation rights of ERISA plans are not saved from preemption by a "common-sense reading" of the savings clause. In *Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989), the court held that while "the law of subrogation is generally applicable to insurance contracts, it is not specifically directed toward the insurance industry." The foregoing authorities demonstrate that the *Baxter* analysis is correct and should be adopted by this Court.

B. The Pennsylvania Anti-Subrogation Statute Does Not Regulate the "Business of Insurance" Within the Meaning of the McCarran-Ferguson Act.

The McCarran-Ferguson Act creates a limited exemption for the "business of insurance" from the federal antitrust laws. This Court has construed the exemption narrowly. Measures to cut costs and maximize efficiency of operations do not constitute the "business of insurance," even when effected by insurance companies. Hence, the subrogation policies at issue in this case could not conceivably fall within McCarran-Ferguson, especially in the context of self-insured plans.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), a group of pharmacists sued an insurance company, Blue Shield, under the antitrust laws. Blue Shield had secured substantial volume discounts for drug purchases by negotiating agreements with pharmacists throughout Texas. When the plaintiffs alleged that the practice amounted to price-fixing and a group boycott, Blue Shield countered that the disputed practice constituted the "business of insurance" and, thus, was exempt under McCarran-Ferguson. This Court disagreed with Blue Shield, noting that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." According to *Royal Drug*:

The Pharmacy Agreements . . . do not involve any underwriting or spreading of risk, but are

merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, *Blue Shield effectively reduces the total amount it must pay to its policyholders*. The Agreements thus enable Blue Cross to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

440 U.S. at 214 (emphasis added). Accord, *United Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982) (utilization review procedure); *Baxter v. Lynn*, 886 F.2d at 186 (subrogation).

The Third Circuit would give cost containment the worst of all worlds, denying both the McCarran-Ferguson antitrust exemption and ERISA preemption. That result would controvert the will of Congress, flout the precedents of this Court, and, in view of the importance of sound cost containment to the health care system, disserve the interests of all American workers and their families.

CONCLUSION

For the foregoing reasons, the opinion of the Third Circuit should be reversed.

Respectfully submitted,

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